# **Standard Platinum Plan**

2018 Standard Plan AV:

88.20%

		2019 Standard Platinum Plan	
2019 Actuarial Value	88.92%		
Individual Overall Deductible		Ç	60
Other Individual Deductible	s for Specific Services		
	Medical	\$0	
Prescription Drugs		Ç	60
Dental		Ç	50
Individual Out-of-Pocket Ma	ximum	\$2,	000
Common Medical Event	Service Type	Member Cost Share	Deductible Applies**
	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an	ć20	
Health Care Provider's	Injury or Illness	\$20	
Office or Clinic visit	Specialist Visit	\$40	
	Preventive Care/Screening/Immunization	\$0	
	Laboratory Tests	\$20	
Tests	X-Rays And Diagnostic Imaging	\$40	
	Imaging (CT/PET scans, MRIs)	\$150	
	Generic	\$5	
Drugs to Treat Illness or	Preferred Brand	\$15	
Condition***	Non-Preferred Brand	\$25	
	Specialty	\$100	
Outpatient Surgery	Facility Fee (e.g. Hospital Room)	\$250	
	Physician/Surgeon Fee		
Outpatient Non-Surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in	\$75	
Clinic visit*	the outpatient department of a hospital/hospital clinic	\$150	
Need Immediate Attention	Emergency Room Services (Waived If Admitted) Emergency Medical Transportation	\$150	
Need illillediate Attention	Urgent Care	\$40	
	Facility Fee (e.g. Hospital Room)	\$250 Per Day	
Hospital Stay	Physician/Surgeon Fee	(Up To 5 Days)	
	Office Visits	\$20	
	Outpatient Services	\$20	
Mental/Behavioral Health	Outputient Services	\$250 Per Day	
	Inpatient Services	(Up To 5 Days)	
	Office Visits	\$20	
Cubatana Abusa Nasala	Outpatient Services	\$20	
Substance Abuse Needs	Lange History Commission	\$250 Per Day	
	Inpatient Services	(Up To 5 Days)	
	Prenatal Care And Preconception Services	\$0	
Pregnancy	Delivery And All Inpatient Services - Hospital	\$250 Per Day	
	Delivery And All Inpatient Services - Prof	(Up To 5 Days)	
	Home Health Care	\$20	
	Outpatient Rehabilitation Services	\$20	
Help Recovering or Other	Outpatient Habilitation Services	\$20	
Special Health Needs	Skilled Nursing Care	\$150 Per Day	
		(Up To 5 Days)	
	Durable Medical Equipment	10%	
	Hospice Services	\$0	
Child Eye Care	Eye Exam	\$0	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0	
	Oral Exam	\$0	
Child Dental Diagnostic and Preventive	Preventive - Cleaning	\$0 \$0	
	Sealants - Per Tooth	\$0 \$0	
	Sealants - Per Tooth Topical Fluoride Application	\$0 \$0	
	Space Maintainers - Fixed	\$0	
Child Dental Basic Services	Amalgam Fill - 1 Surface	\$25	
Simo Dental Dasic Services	Root Canal - Molar	\$300	
	Gingivectomy - Per Quad	\$150	
Child Dental Major Services	Extraction - Single Tooth Exposed Root	\$65	
	Extraction - Complete Bony	\$160	
	Porcelain With Metal Crown	\$300	
Child Orthodontics	Medically Necessary Orthodontics	\$1,000	
	# model IMO setting	T =,000	l .

<sup>\*</sup>Copay may not apply in staff model HMO setting.

 $<sup>{\</sup>bf **If\ deductible\ applies\ to\ benefit,\ member\ must\ first\ satisfy\ the\ deductible\ before\ "Member\ Cost\ Share"\ is\ applied}$ 

<sup>\*\*\*</sup> Cost sharing capped at \$150 per script for specialty drugs

# **Standard Gold Plan**

2018 Standard Plan AV:

81.91%

		2019 Standa	rd Gold Plan
2019 Actuarial Value	81.94%		
Individual Overall Deductible	e	\$5	600
Other Individual Deductible	s for Specific Services		
	Medical	\$5	600
	Prescription Drugs	Ç	60
	Dental	Ç	60
Individual Out-of-Pocket Ma	aximum	\$4,	000
Common Medical Event	Service Type	Member Cost Share	Deductible Applies**
	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an		
Health Care Provider's	Injury or Illness	\$25	
Office or Clinic visit	Specialist Visit	\$50	
	Preventive Care/Screening/Immunization	\$0	
	Laboratory Tests	\$30	
Tests	X-Rays And Diagnostic Imaging	\$50	
	Imaging (CT/PET scans, MRIs)	\$250	
<del>-</del> 	Generic	\$15	
Drugs to Treat Illness or	Preferred Brand	\$50	
Condition***	Non-Preferred Brand	\$70	
	Specialty	\$150	
0	Facility Fee (e.g. Hospital Room)	·	
Outpatient Surgery	Physician/Surgeon Fee	\$600	
Outpatient Non-Surgical	Non-surgical service, not otherwise elaborated herein, rendered in	4	
Clinic Visit*	the outpatient department of a hospital/hospital clinic	\$75	
	Emergency Room Services (Waived If Admitted)	\$300	
Need Immediate Attention	Emergency Medical Transportation	\$300	
	Urgent Care	\$60	
	Facility Fee (e.g. Hospital Room)	\$600 Per Day	.,
Hospital Stay	Physician/Surgeon Fee	(Up To 5 Days)	Х
	Office Visits	\$25	
	Outpatient Services	\$25	
Mental/Behavioral Health		\$600 Per Day	.,
	Inpatient Services	(Up To 5 Days)	Х
	Office Visits	\$25	
Codestantes About Novels	Outpatient Services	\$25	
Substance Abuse Needs	Lorent Comition	\$600 Per Day	V
	Inpatient Services	(Up To 5 Days)	X
	Prenatal Care And Preconception Services	\$0	
Pregnancy	Delivery And All Inpatient Services - Hospital	\$600 Per Day	V
	Delivery And All Inpatient Services - Prof	(Up To 5 Days)	X
	Home Health Care	\$30	
	Outpatient Rehabilitation Services	\$30	
Hala Dassussina as Other	Outpatient Habilitation Services	\$30	
Help Recovering or Other Special Health Needs	Chilled Naming Cone	\$300 Per Day	
special nealth Needs	Skilled Nursing Care	(Up To 5 Days)	
	Durable Medical Equipment	20%	
	Hospice Services	\$0	
Child Eye Care	Eye Exam	\$0	
Ciliu Eye Care	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0	
Child Dental Diagnostic and Preventive	Oral Exam	\$0	
	Preventive - Cleaning	\$0	
	Preventive - X-Ray	\$0	
	Sealants - Per Tooth	\$0	
	Topical Fluoride Application	\$0	
	Space Maintainers - Fixed	\$0	
Child Dental Basic Services	Amalgam Fill - 1 Surface	\$25	
	Root Canal - Molar	\$300	
	Gingivectomy - Per Quad	\$150	
<b>Child Dental Major Services</b>	Extraction - Single Tooth Exposed Root	\$65	
1	Extraction - Complete Bony	\$160	
	Porcelain With Metal Crown	\$300	
Child Orthodontics	Medically Necessary Orthodontics	\$1,000	
*6	ef madel 11000 action		

<sup>\*</sup>Copay may not apply in staff model HMO setting.

 $<sup>{\</sup>bf **If\ deductible\ applies\ to\ benefit,\ member\ must\ first\ satisfy\ the\ deductible\ before\ "Member\ Cost\ Share"\ is\ applied}$ 

<sup>\*\*\*</sup> Cost sharing capped at \$150 per script for specialty drugs

# Standard Silver Plan

71.96% 2018 Standard Plan AV:

		2018 Standard Silver Plan		2019 Silver Alt 1		2019 Sil	ver Alt 2
2019 Actuarial Value		73.22%		72.02%		71.98%	
Individual Overall Deductible		\$3,750			750	\$3,750	
Other Individual Deductibles for Specific Services		<i>\$3,730</i>		<del></del>		\$3,730	
Medical		\$3,500		\$3,500		\$3,500	
Prescription Drugs		\$2	250		150	\$2	250
Dental		\$0		\$0		\$0	
Individual Out-of-Pocket Maximum		\$6,250		\$7,250		\$7,300	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies**	Member Cost Share	Deductible Applies**	Member Cost Share   Deductible Applies*	
	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an		Deduction rippines		Deduction rippines		Deduction replies
	Injury or Illness	\$40		\$40		\$40	
Office or Clinic visit	Specialist Visit	\$80		\$80		\$80	
	Preventive Care/Screening/Immunization	\$0		\$0		\$0	
	Laboratory Tests	\$50		\$50		\$50	
Tests	X-Rays And Diagnostic Imaging	\$70		\$80		\$80	
	Imaging (CT/PET scans, MRIs)	\$250		\$250		\$250	
	Generic	\$15		\$15		\$15	
Drugs to Treat Illness or	Preferred Brand	\$50	х	\$50	Х	\$50	Х
Condition***	Non-Preferred Brand	\$70	X	\$70	X	\$70	X
	Specialty	\$150	X	\$150	X	\$150	X
	Facility Fee (e.g. Hospital Room)	,				,	
Outpatient Surgery	Physician/Surgeon Fee	20%	Х	20%	Х	20%	Х
Outpatient Non-Surgical	Non-surgical service, not otherwise elaborated herein, rendered in						
Clinic Visit*	the outpatient department of a hospital/hospital clinic	20%	Х	20%	Х	20%	Х
	Emergency Room Services (Waived If Admitted)	\$250	Х	\$350	Х	\$350	Х
Need Immediate Attention	Emergency Medical Transportation	\$250	Х	\$350	Х	\$350	Х
	Urgent Care	\$90		\$90		\$90	
	Facility Fee (e.g. Hospital Room)						
Hospital Stay	Physician/Surgeon Fee	20%	Х	20%	Х	20%	Х
	Office Visits	\$40		\$40		\$40	
	Outpatient Services	5%		5%		5%	
Mental/Behavioral Health	Inpatient Services	20%	х	20%	Х	20%	Х
	Office Visits	\$40		\$40		\$40	
	Outpatient Services	5%		5%		5%	
Substance Abuse Needs	Inpatient Services	20%	х	20%	Х	20%	Х
	Prenatal Care And Preconception Services	\$0		\$0		\$0	
Pregnancy	Delivery And All Inpatient Services - Hospital						
	Delivery And All Inpatient Services - Prof	20%	Х	20%	Х	20%	Х
	Home Health Care	\$50		\$50		\$50	
	Outpatient Rehabilitation Services	\$50		\$50		\$50	
	Outpatient Habilitation Services	\$50		\$50		\$50	
Help Recovering or Other Special Health Needs	Skilled Nursing Care	20%	х	20%	Х	20%	х
	Durable Medical Equipment	20%	İ	20%		20%	
	Hospice Services	\$0		\$0		\$0	
Child Fue Core	Eye Exam	\$0		\$0		\$0	
Child Eye Care	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0		\$0		\$0	
Child Dental Diagnostic and Preventive	Oral Exam	\$0		\$0		\$0	
	Preventive - Cleaning	\$0		\$0		\$0	
	Preventive - X-Ray	\$0		\$0		\$0	
	Sealants - Per Tooth	\$0		\$0		\$0	
	Topical Fluoride Application	\$0		\$0		\$0	
	Space Maintainers - Fixed	\$0		\$0		\$0	
	Amalgam Fill - 1 Surface	\$25		\$25		\$25	
	Root Canal - Molar	\$300		\$300		\$300	
Child Dental Major	Gingivectomy - Per Quad	\$150		\$150		\$150	
Child Dental Major Services	Extraction - Single Tooth Exposed Root	\$65		\$65		\$65	
Jei vices	Extraction - Complete Bony	\$160		\$160		\$160	
	Porcelain With Metal Crown	\$300		\$300		\$300	
Child Orthodontics	Medically Necessary Orthodontics	\$1,000	]	\$1,000		\$1,000	

<sup>\*\*</sup>Copay may not apply in staff model HMO setting.

\*\*If deductible applies to benefit, member must first satisfy the deductible before "Member Cost Share" is applied

\*\*\* Cost sharing capped at \$150 per script for specialty drugs

# Standard Silver Plan

71.96% 2018 Standard Plan AV:

		2019 Silver Alt 3		2019 Silver Alt 4		2019 Silver Alt 5	
2019 Actuarial Value		71.87%		71.79%		2019 Silver Alt 5 72.06%	
Individual Overall Deductible		\$4,000			000		,750
Other Individual Deductibles for Specific Services		24,000		Ψ.,	-	Ų,	
Medical		\$3,750		\$3.	750	\$3.	,500
Prescription Drugs							250
Dental		\$250 \$0		\$250 \$0			50
Individual Out-of-Pocket Maximum		\$7,250		\$7,250		\$7,400	
						Member Cost Share   Deductible Applies**	
Common Medical Event	Service Type	iviember Cost Share	Deductible Applies**	Member Cost Share	Deductible Applies**	iviember Cost Share	Deductible Applies**
Haalah Cana Buandalada	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an	\$40		\$40		\$40	
Health Care Provider's	Injury or Illness	400		400		400	
Office or Clinic visit	Specialist Visit	\$80		\$80		\$80	
	Preventive Care/Screening/Immunization	\$0		\$0		\$0	
	Laboratory Tests	\$50		\$50		\$50	
Tests	X-Rays And Diagnostic Imaging	\$70		\$75		\$70	
	Imaging (CT/PET scans, MRIs)	\$250		\$250		\$250	
	Generic	\$15		\$15		\$15	
Drugs to Treat Illness or	Preferred Brand	\$50	X	\$50	X	\$50	X
Condition***	Non-Preferred Brand	\$70	X	\$70	X	\$70	X
	Specialty	\$150	Х	\$150	X	\$150	Х
Outpatient Surgery	Facility Fee (e.g. Hospital Room)	20%	х	20%	Х	20%	Х
	Physician/Surgeon Fee						1
Outpatient Non-Surgical	Non-surgical service, not otherwise elaborated herein, rendered in	20%	х	20%	Х	20%	х
Clinic Visit*	the outpatient department of a hospital/hospital clinic			40	,.	40	
	Emergency Room Services (Waived If Admitted)	\$350	Х	\$350	X	\$350	Х
Need Immediate Attention	Emergency Medical Transportation	\$350	Х	\$350	X	\$350	Х
	Urgent Care	\$90		\$90		\$90	
Hospital Stay	Facility Fee (e.g. Hospital Room)	20%	х	20%	Х	20%	Х
	Physician/Surgeon Fee						
	Office Visits	\$40		\$40		\$40	
Mental/Behavioral Health	Outpatient Services	5%		5%		5%	
	Inpatient Services	20%	Х	20%	Х	20%	Х
	Office Visits	\$40		\$40		\$40	
Substance Abuse Needs	Outpatient Services	5%		5%		5%	
	Inpatient Services	20%	x	20%	Х	20%	х
	Prenatal Care And Preconception Services	\$0		\$0		\$0	
Pregnancy	Delivery And All Inpatient Services - Hospital	200/		200/	v	200/	V
	Delivery And All Inpatient Services - Prof	20%	х	20%	Х	20%	Х
	Home Health Care	\$50		\$50		\$50	
	Outpatient Rehabilitation Services	\$50		\$50		\$50	
	Outpatient Habilitation Services	\$50		\$50		\$50	
Help Recovering or Other Special Health Needs	Skilled Nursing Care	20%	х	20%	Х	20%	х
	Durable Medical Equipment	20%	İ	20%		20%	<u> </u>
	Hospice Services	\$0		\$0		\$0	
0.11.5	Eye Exam	\$0		\$0		\$0	
Child Eye Care	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0	1	\$0		\$0	
Child Dental Diagnostic and Preventive	Oral Exam	\$0	1	\$0		\$0	
	Preventive - Cleaning	\$0	1	\$0		\$0	
	Preventive - X-Ray	\$0		\$0		\$0	
	Sealants - Per Tooth	\$0		\$0		\$0	
	Topical Fluoride Application	\$0		\$0		\$0	
	Space Maintainers - Fixed	\$0		\$0		\$0	İ
Child Dental Basic Services Amalgam Fill - 1 Surface		\$25		\$25		\$25	
	Root Canal - Molar	\$300		\$300		\$300	
	Gingivectomy - Per Quad	\$150	İ	\$150		\$150	
Child Dental Major	Extraction - Single Tooth Exposed Root	\$65	1	\$65		\$65	
Services	Extraction - Complete Bony	\$160		\$160		\$160	
	Porcelain With Metal Crown	\$300	1	\$300		\$300	
Child Orthodontics	Medically Necessary Orthodontics	\$1,000	İ	\$1,000		\$1,000	
	ff Living wi	T =,000		+=,000	l	+=,000	

<sup>\*\*</sup>Copay may not apply in staff model HMO settling.

\*\*If deductible applies to benefit, member must first satisfy the deductible before "Member Co"

\*\*\* Cost sharing capped at \$150 per script for specialty drugs

# **Standard Bronze Plan**

64.81% 2018 Standard Plan AV:

		2018 Standard Bronze Copay Plan		2019 Standard Bronze Copay Plan Alt 1		2019 Standard Bronze Copay Plan Alt 2		
2019 Actuarial Value		66.20%		65.21%		64.99%		
Individual Overall Deductible		\$6,600			850		100	
Other Individual Deductibles for Specific Services		+-,		÷ =,000				
Medical		\$6,	,000	\$6,	250	\$6,	500	
Prescription Drugs			500		600		600	
Dental		\$0		\$	60	Ç	\$0	
Individual Out-of-Pocket Maximum		\$7,350		\$7,850		\$7,900		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies**	Member Cost Share	Deductible Applies**	Member Cost Share	Deductible Applies**	
	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an							
Health Care Provider's	Injury or Illness	\$50		\$50		\$50		
Office or Clinic visit	Specialist Visit	\$75		\$80		\$80		
	Preventive Care/Screening/Immunization	\$0		\$0		\$0		
	Laboratory Tests	\$55	Х	\$55	Х	\$55	Х	
Tests	X-Rays And Diagnostic Imaging	\$75	Х	\$80	Х	\$80	Х	
	Imaging (CT/PET scans, MRIs)	\$500	Х	\$500	Х	\$500	Х	
	Generic	\$25		\$25		\$25		
Drugs to Treat Illness or	Preferred Brand	\$75	Х	\$75	Х	\$75	Х	
Condition***	Non-Preferred Brand	\$100	Х	\$100	Х	\$100	Х	
	Specialty	\$150	Х	\$150	X	\$150	Х	
Outpatient Surgery	Facility Fee (e.g. Hospital Room)	25%	х	25%	Х	25%	х	
Outputient Surgery	Physician/Surgeon Fee	2570	^	2570	^	2570	^	
Outpatient Non-Surgical	Non-surgical service, not otherwise elaborated herein, rendered in	25%	х	25%	Х	25%	х	
Clinic Visit*	the outpatient department of a hospital/hospital clinic						^	
	Emergency Room Services (Waived If Admitted)	25%	Х	25%	Х	25%	Х	
Need Immediate Attention	Emergency Medical Transportation	25%	Х	25%	X	25%	X	
	Urgent Care	\$100		\$100		\$100		
Hospital Stay	Facility Fee (e.g. Hospital Room)	25%	х	25%	Х	25%	Х	
	Physician/Surgeon Fee			1-1		1		
	Office Visits	\$50		\$50		\$50		
Mental/Behavioral Health	Outpatient Services	10%		10%		10%		
	Inpatient Services	25%	х	25%	Х	25%	Х	
	Office Visits	\$50		\$50		\$50		
Substance Abuse Needs	Outpatient Services	10%		10%		10%		
	Inpatient Services	25%	x	25%	Х	25%	Х	
	Prenatal Care And Preconception Services	\$0		\$0		\$0		
Pregnancy	Delivery And All Inpatient Services - Hospital	25%	х	25%	Х	25%	Х	
	Delivery And All Inpatient Services - Prof	2570	^	2570	^	2570	^	
	Home Health Care (Up to 90 Visits for 4 Hours per Calendar Yr)	\$50	X	\$50	X	\$50	Х	
	Outpatient Rehabilitation Services	\$50	Х	\$50	X	\$50	X	
Help Recovering or Other	Outpatient Habilitation Services	\$50	Х	\$50	X	\$50	Х	
Special Health Needs	Skilled Nursing Care	25%	Х	25%	Х	25%	Х	
	Durable Medical Equipment	25%	Х	25%	X	25%	Х	
	Hospice Services	25%	X	25%	X	25%	Х	
Child Eye Care	Eye Exam (OD)	\$50		\$50		\$50		
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0		\$0		\$0		
Child Dental Diagnostic and Preventive	Oral Exam	\$0		\$0		\$0		
	Preventive - Cleaning	\$0		\$0		\$0		
	Preventive - X-Ray	\$0	-	\$0		\$0		
	Sealants - Per Tooth	\$0		\$0		\$0		
	Topical Fluoride Application	\$0		\$0		\$0		
Space Maintainers - Fixed		\$0 \$41		\$0 \$41		\$0 \$41		
Child Dental Basic Services	Amalgam Fill - 1 Surface	\$41		\$41		\$41		
	Root Canal - Molar	\$512 \$270		\$512 \$270		\$512 \$270		
Child Dental Major 📙	Gingivectomy - Per Quad  Extraction - Single Tooth Exposed Root	\$279		\$279		\$279		
Services	Extraction - Single Tooth Exposed Root Extraction - Complete Bony	\$69 \$241		\$69		\$69 \$241		
	Porcelain With Metal Crown	\$241 \$523	1	\$241 \$523		\$241 \$523		
Child Orthodontics	Medically Necessary Orthodontics	\$3,422		\$3,422		\$3,422		
Cima Of thoughties	inicultaily necessary Orthodontics	<i>\$</i> 3,422	1	<i>\$</i> 3,422	I	<i>\$</i> 3,422	l	

<sup>\*\*</sup>Copay may not apply in staff model HMO setting.

\*\*If deductible applies to benefit, member must first satisfy the deductible before "Member Cost Share" is applied

\*\*\* Cost sharing capped at \$150 per script for specialty drugs

# **Standard Bronze Plan**

60.61% 2018 Standard Plan AV:

		2019 Standard Bronze HDHP Plan		
2019 Actuarial Value	61.82%			
Individual Overall Deductib	le	\$6,200		
Other Individual Deductible	es for Specific Services			
	Medical	\$6,200		
Prescription Drugs		Integrated v	with Medical	
Dental		\$0		
Individual Out-of-Pocket M	aximum	\$6,	550	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies**	
	Primary Care Visit Or Non-Specialist Practitioner Visit to Treat an	20%	х	
Health Care Provider's	Injury or Illness			
Office or Clinic visit	Specialist Visit	20%	X	
	Preventive Care/Screening/Immunization	\$0		
T4-	Laboratory Tests	20%	X	
Tests	X-Rays And Diagnostic Imaging	20%	X	
	Imaging (CT/PET scans, MRIs) Generic	20%	X	
Drugs to Treat Illness or	Preferred Brand	20%	X	
Condition***	Non-Preferred Brand	20%	X	
	Specialty	20%	X	
	Facility Fee (e.g. Hospital Room)			
Outpatient Surgery	Physician/Surgeon Fee	20%	Х	
Outpatient Non-Surgical	Non-surgical service, not otherwise elaborated herein, rendered in	20%	X	
Clinic Visit*	the outpatient department of a hospital/hospital clinic	20%	X	
	Emergency Room Services (Waived If Admitted)	20%	X	
Need Immediate Attention	Emergency Medical Transportation	20%	X	
	Urgent Care	20%	Х	
Hospital Stay	Facility Fee (e.g. Hospital Room)	20%	х	
	Physician/Surgeon Fee			
	Office Visits	20%	X	
Mental/Behavioral Health	Outpatient Services	20%	X	
	Inpatient Services	20%	Х	
	Office Visits	20%	X	
	Outpatient Services	20%	X	
Substance Abuse Needs	outputient services			
	Inpatient Services	20%	Х	
	Prenatal Care And Preconception Services	\$0		
Pregnancy	Delivery And All Inpatient Services - Hospital	20%	Х	
	Delivery And All Inpatient Services - Prof	20%	^	
	Home Health Care (Up to 90 Visits for 4 Hours per Calendar Yr)	20%	X	
	Outpatient Rehabilitation Services	20%	Х	
Help Recovering or Other	Outpatient Habilitation Services	20%	X	
Special Health Needs	Skilled Nursing Care	20%	х	
	Durable Medical Equipment	20%	X	
	Hospice Services	20%	X	
	Eye Exam (OD)	\$50	^	
Child Eye Care	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0		
	Oral Exam	\$0		
	Preventive - Cleaning	\$0		
Child Dental Diagnostic	Preventive - X-Ray	\$0		
and Preventive	Sealants - Per Tooth	\$0		
	Topical Fluoride Application	\$0		
	Space Maintainers - Fixed	\$0		
Child Dental Basic Services		\$41		
	Root Canal - Molar	\$512		
Child Dental Major	Gingivectomy - Per Quad	\$279		
Services	Extraction - Single Tooth Exposed Root	\$69		
	Extraction - Complete Bony	\$241		
Child Outhods :: *!	Porcelain With Metal Crown	\$523		
Child Orthodontics  *Copay may not apply in st	Medically Necessary Orthodontics	\$3,422		

<sup>\*\*</sup>Copay may not apply in staff model HMO setting.

\*\*If deductible applies to benefit, member must first satisfy the deductible before "Member Co"

\*\*\* Cost sharing capped at \$150 per script for specialty drugs